Innovations
IN CONTINUING CARE
VOLUME 2, NUMBER 2, SUMMER 97

Transitional (Short-term) Care

Transitional (Short-term) Care is one of the new ways of meeting client needs, and is included as part of the New Models in Continuing Care Demonstration Project.[1] Transitional Care is an innovative program which complements existing regional services by providing short-term rehabilitation, with the goal of discharging clients back to their own homes. Transitional Care is intended to provide short-term, cost-effective alternatives to acute care hospitals or continuing care centers. The objectives of Transitional Care are to:

- prevent admissions to acute care, which in turn frees up beds for more appropriate acute admissions. The client cost is less for Transitional Care than acute care.
- provide a more appropriate setting where staff, the environment and resources are attuned to the rehabilitation needs of elderly individuals.
- enable individuals to return home and maintain their independence in the community.
- enable families/caregivers to continue to provide care in the community by linking them with supportive services.

These objectives are consistent with the goals of health reform.

Four transitional projects were selected for inclusion in the Demonstration Project. These programs focus on rehabilitation, promoting independence and improving quality of life.

The programs are:

- *Central Park Lodge, Almost Home Program, Edmonton*
- *Allen Gray Continuing Care Centre, Alternate Transitional Care, Edmonton*
- *Foothills Hospital, Short Term Care in a Continuing Care Centre, Calgary*
- *Peace Health Region, Short Term Assessment and Rehabilitation (STAR) Unit, Peace River*

Transitional Care is an innovative program which compliments existing regional services by providing short-term rehabilitation.

This issue of *Innovations in Continuing Care* completes the profiles of the six innovative continuing care projects delivered on 12 sites throughout Alberta. The next issue of Innovations (volume 2, number 3, Fall 1997) will begin to document what was learned in this Demonstration Project.

Six models at 12 sites

Adult Family Living
Carewest
Rimbey and District HCC
Capital Care Group

Assisted Living
Good Samaritan Society

Dementia Care
Capital Care Group

Native Heritage Enrichment
J.B. Wood Extended Care

Integrated Community Care Programs
Capital Health Authority
Cold Lake HCC

Transitional Care
Foothills Hospital
Central Park Lodge
Allen Grey Auxiliary
Peace Health Region

The final issue of *Innovations* (volume 2, number 4) will present excerpts from the final Evaluation Report.

[1] A project funded by Health Canada's New Horizons Program

Central Park Lodge – Almost Home Transitional Care Program

The Almost Home program is a short-term rehabilitation program for elderly persons. The program is intended to provide a thorough community based rehabilitation treatment program for individuals near or within their own community. The program is targeted to individuals who require a higher level of care and intervention than is available through home care or community rehabilitation services.

The program is intended to provide a thorough community-based rehabilitation treatment program for individuals within their own community.

The program focuses on clients who:

- are eligible for early discharge from acute care.
- have experienced a temporary loss of independence or reduction in optimal functional level due to a change in health status or support system.
- require short-term rehabilitation services.

The type of client that is most appropriate for the Almost Home Program includes:

- Post-surgical (e.g. orthopedic, cataract, dental extraction) clients who require extra care or who are experiencing complications arising while in their homes.
- Clients with medical conditions who require monitoring, treatment, or further teaching regarding effective management of a particular problem (e.g., bladder control problems, arthritic conditions, dehydration, hypertension or cardiovascular problems).

The type of clients not eligible for admission are those who have acute or medically unstable disease processes, such as Chronic Obstructive Pulmonary Disease (COPD), those who need Total Parenteral Nutrition (TPN), those with wound management problems or people with constant care requirements.

A multi-disciplinary team of professionals including a registered nurse, occupational therapist, physical therapist, dietitian, pharmacist and foot care nurse provide information, counseling and instruction to the client, their family and/or caregiver regarding proper care and management of their problem. Other core team members include physicians, social workers/community liaison staff and a care manager.

Clients generally stay in the program from a few days to six weeks. The Almost Home Program can accommodate up to four transitional care clients at one time. The accommodation charge for a semi-private room is $26.25 per client per day.

Central Park Lodge has included clients and their families in all phases of planning the Almost Home program, through the use of questionnaires, surveys, informal interviews and contact with external community agencies. The community agencies that were contacted included Veterans Affairs Canada, Central Assessment and Placement Services, church groups, the Alzheimer's and Parkinson's Societies, public health units, physicians, home care agencies, day support programs and the Society for the Retired and Semi-Retired. Partnerships with referral agencies such as Central Assessment and Placement Services and Home Care Services were established to implement this program.

Information about the Almost Home Program can be obtained by contacting Nives Zvonkovic, Administrator or Lise Boucher, Director of Nursing, Central Park Lodge, 5905 – 112 Street, Edmonton, Alberta T6H 3J4.
Phone: (403)434-1451 or fax: (403)436-4300.

Foothills Hospital – Transitional Care Program

The Transitional Care Program at the Foothills Hospital is an example of how continuing care beds can be better utilized to integrate services provided in the acute care, community and continuing care sectors. The short term services provided by the program include: IV therapy, post-surgical convalescence, palliative care, health care education (e.g., for self-care dialysis patients with cyclers), spousal and family support of residents, and interventions for persons with dementia.

Substantial cost savings to the health care system may be realized if the resident can be successfully maintained in a continuing care setting.

What is Peritoneal Dialysis?

Peritoneal dialysis is a process of cleansing the blood. This process is performed inside the body by using the body's own peritoneal membrane as a filter. A dialysis exchange involves draining the dialysis solution from the peritoneal cavity and replacing it with fresh solution. A cycler is a machine that allows for dialysis exchanges to occur over a period of time. Peritoneal dialysis, by way of the cycler, is generally initiated at night and occurs over a period of 8 - 10 hours.

The program to date, has focused on two specific client groups – those who require peritoneal dialysis (self-care dialysis patients with cyclers), and individuals with altered respiratory function who require additional support.

The program was initially designed to meet the needs of individuals with a diagnosis of chronic renal failure who require peritoneal dialysis and who have been assessed as appropriate for admission to a continuing care facility. This program allows these individuals to complete their exchanges during their hours of sleep, as opposed to having their treatments on the outpatient renal unit four times daily. It also provides them with the opportunity to live in a home-like setting in continuing care, instead of remaining in acute care. Substantial cost savings to the health care system may be realized if the resident can be successfully maintained in a continuing care setting.

In June, 1996, the project was expanded to include residents with altered respiratory function, who require additional support (e.g., tracheostomy care, oxygen therapy, respiratory therapy consultation, chest physiotherapy, weekly respiratory assessments, etc.). The program was developed with the collaboration and support of the Respiratory Therapy department at the Foothills Hospital, who provide education, expertise, and assistance to clients in the program.

A multi-disciplinary team of professionals including continuing care managers and staff, renal specialty staff, respiratory therapists, physiotherapists, infection prevention staff, and physicians, provide care, information, counseling and instruction to clients and their families.

This program can accommodate up to four transitional care clients at one time. Clients can choose either semi-private or private accommodation. The charge for a semi-private room is

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Foothills Hospital continued from panel 4

$26.25 per client per day, and the charge for a private room is $28.60 per client per day.

The program has several benefits: clients non-acute treatment needs are met in a cost-effective and home-like environment; it is responsive and flexible to the needs of clients in the acute and community health sectors; the program has the potential to decrease the average length of stay in acute care, and postpone/avoid admission to acute or other continuing care centres; and, it successfully introduced new technology to continuing care (cyclers for self-care dialysis patients).

Information about this Transitional Care Program can be obtained by contacting Judy Hanson, Administrative Director, Foothills Hospital, 1403 – 29 Street N.W., Calgary, Alberta T2N 2T9.
Phone: (403)670-1526 or fax: (403)670-1067.

Peace Health Region – Short-term Assessment and Rehabilitation (STAR) Program

The program is intended for those individuals who do not require full-time residency in a continuing care centre.

The underlying philosophy of the STAR Program is to provide short-term assessment and rehabilitation to individuals in the Peace Health Region. The program is intended for those individuals who do not require full-time residency in a continuing care centre, but have short-term needs that exceed the existing resources available in home care; or, those individuals who require assessment to ensure health needs and level of care are matched.

Referrals to the program are made by various health care professionals. Eligibility criteria include individuals who:

- are 18 years of age or older, who are medically stable and not predicted to deteriorate to a more acute level of illness;
- have received initial treatment in a referral facility;
- are able to learn and participate in their treatment, rehabilitation, or convalescence;
- can be discharged to original residence, i.e., home, lodge;
- have care requirements that fall within the program capabilities/resources, and whose length of stay is anticipated to be from 14 to 90 days;
- require on-going physician monitoring;
- lack the ability to safely manage daily living needs at home, by the projected date of discharge from acute care;
- need further medical and/or other treatment that cannot be provided in a simple and efficient manner in the individual's home, and acute care is not required.

The Regional Placement Coordinator, along with the area home care nurse, are involved in receiving referrals and screening clients. Before admission to the program a care plan, including discharge planning, is established.

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Allen Gray Continuing Care Centre – Transitional Care Program

The Transitional Care Program at the Allen Gray Continuing Care Centre is designed for clients in the community who require more services than home care can provide, but who do not require the intensity of acute care hospitals. This program, unlike subacute care that facilitates early discharge from an acute care setting, is intended to prevent admission to acute care. The program provides rehabilitative and skilled nursing services for clients who cannot be maintained at home because of an unstable condition, the lack of family skill/support, or who require more services than home care can provide.

The objectives of the program are to:

- provide health care intervention in a cost-effective manner.
- provide an environment that maximizes potential for quality of life.
- discharge the client back home for independent living, with appropriate community health support.

The type of client that is most appropriate for this Transitional Care Program include elderly adults in the community who have:

- chronic conditions e.g., rheumatoid arthritis, multiple sclerosis, Parkinson's disease, etc.
- medical conditions such as diabetes, pneumonia, emphysema, etc.
- malnourishment, dehydration, or may require management of bowel and bladder problems.
- wound management problems, such as decubitus and varicose ulcers.

Admissions to the program are received on a 24 hour a day basis, seven days a week. The Transitional Care Program is available for clients who require short term convalescence for up to 90 days. Staff from the Allen Gray Continuing Care Centre work closely with staff from the Capital Health Authority Home Care Program and Continuing Care Division. The following services are provided through the program: medical surveillance; nursing intervention; physical therapy; occupational therapy; leisure and recreational counseling; health teaching for clients and families; nutritional counseling; pastoral care; and discharge planning.

The program can accommodate up to four clients at one time. The accommodation charge for a semi-private room is $26.25 per client per day.

Several partnerships have been instrumental in developing this program, including Capital Health Authority Home Care, the Grey Nuns Hospital and Capital Health Authority Regional Services. The Capital Health Authority Central Assessment and Placement Service is also an integral partner, referring appropriate clients to the program. Clients and families in the community have been receptive of this new program, and they have expressed appreciation for receiving timely help, for avoiding acute care and taking the stress off of families during periods of crisis.

Information about this Transitional Care Program can be obtained by contacting Daphne Daniels, Director of Nursing, Allen Gray Continuing Care Center, 7510 – 89 Street, Edmonton, Alberta T6C 3J8.
Phone: (403)469 - 2371
or fax: (403)465 - 2073.

Home care support staff may be involved in providing care, as part of the discharge planning.

This program allows the client and the family time to come to terms with their care requirements and make necessary arrangements and informed decisions. It also allows time for a comprehensive assessment to be completed. Home support, supplies and equipment can be arranged. The program also helps to reduce admissions to, and reduce lengths of stay in, acute care.

The STAR Program is located in the Sutherland Nursing Home, which is part of the Peace River Hospital Complex. To date, there have been 20 clients admitted to the STAR Program, who ranged in age from 38 to 92 years old. They were admitted for fractures, limb surgery, diabetic management, stroke rehabilitation, motor vehicle accident rehabilitation, or emotional crisis intervention. Eighteen individuals have been discharged; eight were discharged to a continuing care center, nine were discharged home, and one was discharged to an acute care facility. The average length of stay has been 36 days. The accommodation charge for a semi-private or private room for the program, is $15.00 per client per day.

Many significant partnerships were established to implement this program in the Peace Health Region, including the Community Rehabilitation Program, home care, continuing care, acute care, Single Point of Entry, and physicians. The partnership with the Regional Seniors' Wellness Group has greatly improved communications and understanding with seniors, and has helped in responding to their needs in all parts of the region. Opportunities for other partnerships exist with Glenrose Rehabilitation clinical specialists and medical specialists in urban referral centers, Social Services, AADAC, and the Office of the Public Guardian.

Information about the Short Term Assessment and Rehabilitation (STAR) Program can be obtained by contacting Eunice Sloan, Regional Community Care Coordinator, Box 6178, 10915 – 99 Street, Peace River, Alberta T8S 1S2. Phone: (403)624-7260; fax: (403)618-3405.

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Innovations in Continuing Care is published four times a year. Submissions, questions, and letters are welcome and should be sent to Project Co-ordinator Bruce Finlayson, c/o New Models in Continuing Care Demonstration Project, 24th Floor, Box 2222, 10025 Jasper Avenue, Edmonton, Alberta, T5J 2P4.

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